FORM APPROVED
OMB NO. 0938-0193

HEALTH CARE FINANCING ADMINISTRATION

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-005

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 15, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902 (n) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 7.7 million
b. FFY 2005 $ 30.8 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Page 7;
Attachment 4.19-D Exhibit A Pages 2 & 3;
Attachment 4.19-D Exhibit B Pages 9,10,12,13, &15.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Price-Based Nursing Facility Services Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Shannon Turner /SM

13. TYPED NAME: Shannon Turner

14. TITLE: Deputy Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 9/30/04

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: April 19, 2005

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 15 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G Smith

21. TYPED NAME: Dennis G Smith

22. TITLE: Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

09/30/2004 14:50 FAX

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 2.0 and RUGS III is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for those recipients.

1. There will be two major categories for the standard price:

   a. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non-personnel operation costs (supplies, etc.). The case-mix adjustable portion will be separated into urban and rural designations based on Metropolitan Statistical Area definitions; and

   b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Metropolitan Statistical Area definitions.

      Effective July 1, 2004, rates are increased $7.60 per day.

2. Each July 1 the rate will be increased by an inflation allowance using the appropriate Data Resource Incorporated (DRI) Index for inflation. The DRI will not be applied to the capital cost component.

3. Capital Cost Add-on:
   Each nursing facility will be appraised by November 30, 1999. The appraisal contractor will use the E. H. Boeckh Co. Evaluation System for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:
   a. Forty thousand dollars per licensed bed;
   b. Two thousand dollars per bed for equipment;
   c. Ten percent of depreciated replacement cost for land value;
   d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
   e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

5. Renovations to nursing facilities in non-appraisal years:
   a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
   b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $ 150,000.

6. Facilities Protection Period
   a. Rate Protection – Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July 1, 1999, unless a facility's "resident acuity" changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
   b. Case Mix – Until July 1, 2000, no facility will receive an average case-mix weight lower than the case-mix weight used for the January 1, 1999 rate setting. After July 1, 2000 the facility shall receive the case-mix weight as calculated by RUGs III from data extracted from MDS 2.0 information.
   c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components.
8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

Methods and Standards for Determining Price-based Nursing Facility Payments

The methods and standards for the determination of reimbursement rates to price-based nursing facilities is described in the Nursing Facility Reimbursement manual which is ATTACHMENT 4.19-D, Exhibit B.

Payment Rates Resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

2. The standard price is market-based using historical data, salary surveys and staffing ratios. The standard price accounts for the higher wage rates for the urban area and the slightly lower rates for wages in the rural area.

3. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Data Resources Incorporated inflation index.

4. The rate also takes into account a facility specific capital cost component based on an appraisal of each facility.

5. The standard price consists of two components: the "case-mix" adjustable portion and the "non-case-mix" adjustable portion.

   (1) The "case-mix" adjustable portion consists of wages for direct care personnel, cost associated with direct care, and non-personnel operation cost (supplies, etc.).

2. Non-personnel operating 6%;
3. Administration 13%;
4. Food 4%;
5. Professional supports & consultation 2%;
6. Non-capital facility related cost 3%; and
7. Capital rate 7%.

E. The standard price shall be adjusted for inflation every July 1 using the Data Resource Incorporated (DRI) Healthcare Index.

F. A portion of the standard price for both urban and rural facilities will be adjusted each calendar quarter for "case-mix". The "case-mix" adjusted portion shall include the following:

1. The personnel cost of a:

   (a) DON-Director of Nursing;
   (b) RN-Registered Nurse;
   (c) LPN-Licensed Practical Nurse;
   (d) Nurse Aide;
   (e) Activities worker; and
   (f) Medical records director.

2. The non-personnel operating cost including:

   (a) Medical supplies; and
   (b) Activity supplies.

G. The "non-case-mix" portion of the standard price shall not be adjusted for case mix and includes:

1. Administration;
2. Non-direct care personnel;
3. Food;
4. Non-capital related costs;
5. Professional support;
6. Consultation;
7. Capital cost component; and
8. An allowance to offset a provider assessment.

H. The capital cost component shall be an "add-on" to the " non case-mix" adjusted portion of the rate.

I. Ancillaries are services for which a separate charge is submitted and include:

1. Speech Therapy;
2. Occupational Therapy;
3. Physical Therapy;
4. Oxygen Services;
5. Laboratory; and
6. X-ray.

J. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.

K. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursement shall be computed by dividing the hours of usage by

that a cost increase occurred as a result of licensure requirement or policy interpretation.

3. The provider shall submit any documentation required by the department.

SECTION 140. PRICE- BASED NF REIMBURSEMENT CALCULATION

A. For each calendar quarter, based on the classification of urban and rural, the department shall calculate an individual NF's price-based rate to be the sum of:

1. The case-mix adjustable portion of a NF Standard Price, adjusted by the individual NF's current average case-mix index. Except that until June 30, 2000 the average case-mix index shall be the greater of the current average case-mix index or the case-mix average calculated as a ratio of the facility's case-mix index to the statewide average case-mix index that would have been used for January 1, 2000 rate setting. After July 1, 2000 the individual NF's actual average case-mix shall be used in the rate calculation; and
2. The non-case-mix adjustable portion of the assigned total Standard Price and the capital cost component.

B. A capital cost component shall be calculated on an individual facility basis based on the facility appraisal completed in November 1999. The Department shall contract with a certified appraisal company to perform the appraisal using the E.H. Boeckh Valuation System. The appraisal is based on the depreciated replacement value of the individual facility. The same Appraisal Company shall perform any re-appraisal that may be requested by a facility within that five-year period.

C. A facility may request a re-appraisal within five years should renovations or additions have a minimum total cost of $150,000 for facilities with more than sixty (60) licensed beds. For facilities having sixty (60) or less licensed beds, the total renovation or addition must be a

minimum total cost of $75,000. The individual NF shall submit written proof of construction cost to the department in order to request a reappraisal. The individual NF shall reimburse the department's contracted appraisal company for the cost of the appraisal. The department shall reimburse the facility the cost of the appraisal or re-appraisal upon receipt of a valid copy of the paid invoice from the Appraisal Company.

D. A capital cost component shall be calculated on an individual facility basis. A capital cost component based on the results of the appraisal shall be the total of the average licensed bed value and ten (10) percent of the licensed bed value for land on which the NF is built. To this sum, add two thousand dollars per licensed bed for equipment. To determine the rate of return for capital cost, multiply the sum of the preceding paragraph by the yield on a twenty (20) year Treasury bond plus a risk factor of two (2) percent. The rate of return shall be no less than nine (9) percent or greater than twelve (12) percent per state fiscal year. The final calculation to determine the individual NF's capital cost component shall be the product of the rate of return calculation divided by the total number of NF bed days as calculated in paragraph F of this section.

E. To determine the average licensed bed value, the depreciated replacement cost of the NF shall be divided by the total number of licensed beds in the NF with the following limitations:
   1. The average bed value shall not exceed $40,000; and
   2. Shall exclude:
      (a) Equipment; and
      (b) Land.

F. NF bed days used in the capital cost rate calculation shall be based on actual bed occupancy, except that the occupancy rate shall not be less than ninety (90) percent of certified bed days.

G. The department shall utilize a rate of return for capital costs that shall be equal to the yield on a twenty (20) year Treasury bond as of the first business day on or after May 31 of each year. Should a change of ownership occur pursuant to 42 CFR 447.253 (2)(d), the new owner shall continue to receive the capital

E. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1:479.

SECTION 170. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR).

A. Prior to admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

B. The department shall reimburse a NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.

C. Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

SECTION 180. NF PROTECTION PERIOD AND BUDGET CONSTRAINTS

A. For the period of January 1, 2000 through June 30, 2002, a NF shall not receive a rate that is less than the rate that was set for the NF pursuant to 907 KAR 1:025E on July 1, 1999, including any capital cost and extenuating circumstances add-ons.

B. The department shall monitor payments on a monthly basis to ensure that aggregate payments made to NF's do not exceed the appropriated funds in fiscal years 2000 through 2002.

C. In order to monitor the payments, the department shall on a monthly basis notify the industry's representatives in writing the total payment amount for the preceding month.

D. The department shall also place on the Medicaid Internet site the amount of payment in aggregate to the NF's for the preceding month and the cumulative amount paid for the current state fiscal year.